Character failings in the surgeon fallen from grace: a thematic analysis of disciplinary hearings against surgeons 2016–2020

Ross Elledge,[1] June Jones[2]

[1]Department of Oral and Maxillofacial Surgery, University Hospitals Birmingham NHS Foundation Trust, Birmingham, UK
[2]Faculty of Health, Social Care & Medicine, Edge Hill University, Ormskirk, UK

Correspondence to
Ross Elledge, Department of Oral and Maxillofacial Surgery, University Hospitals Birmingham NHS Foundation Trust, Birmingham, Birmingham, UK; ross.elledge@nhs.net

Received 18 August 2020
Revised 23 November 2020
Accepted 29 November 2020

To cite: Elledge R, Jones J. *J Med Ethics* Epub ahead of print: [please include Day Month Year]. doi:10.1136/medethics-2020-106809

ABSTRACT

Surgeons are commonly evaluated with respect to outcomes and adherence to rules and regulations, rather than a true holistic examination of the character of the surgeon in question. We sought to examine the character failings of surgeons who faced fitness to practice enquiries under the Medical Practitioner Tribunal Service in the UK. In particular, we examined the absence of virtue as perceived through the lens of Aristotelian ethics using thematic analysis of tribunal hearing transcripts from 2016 to 2020. We identified three overarching themes that are explored in depth: 'the god complex', 'reputation over integrity' and 'wounded pride'. We hope to use this as the foundation for a re-examination of the place of phronesis in postgraduate surgical education, which we argue should be perceived as an exercise in character development and reformation rather than the simplistic teaching of skills to standardised outcomes.

INTRODUCTION

Surgeons are commonly evaluated with reference to their performance. This can be measured objectively during training by effectively grading actions in work-based assessments such as procedure-based assessments and direct observation of procedural skills in surgery (DOPs).[1] This continues beyond training into independent practice where surgeons may be required to publish outcomes data and generate objective feedback on specific areas of care in the shape of patient-reported outcome measures and patient-reported experience measures among other formats.[2 3] In effect, we ask surgeons to follow 'rules' laid down by regulatory bodies such as the General Medical Council (GMC),[4] and measure their performance in an act-centred ethical approach which is both deontological (how well surgeons 'obey the rules' when acting) and consequentialist (whether they achieve desired outcomes as a result of their actions).

Previous work has highlighted the possible role for Aristotelian virtue ethics in postgraduate surgical education, focusing on the character of the individual rather than a particular act as the determinant of 'goodness[5 6]' The view that ethics should be concerned with character dates back to Aristotle, who claimed that virtuous actions are not good merely because they have the appropriate quality, but because the performer of these actions is in an appropriate frame of mind and proceeds from a 'fixed and unchangeable disposition[7]' to act from the right motivation. Action proceeding from judgement has been described as 'a more authentic form of human endeavour than rule-generating or rule-following behaviour[8]". Aristotle went beyond claims about virtuous actions, he provided a framework for understanding the virtuous character which leads to virtuous action.

With this in mind, we sought to examine pervasive character failings in those surgeons who have 'fallen from grace' to better understand the pitfalls that may have lead to disciplinary hearings for individuals who may have always 'obeyed the rules' and appeared to have achieved objectively good outcomes up until their downfall.

METHODS

We requested previously published transcripts of conduct hearings involving surgeons carried out by the Medical Practitioner Tribunal Service (MPTS) in the UK between 2016 and 2020. There were a total of 68 Tribunal hearings involving surgeons during this period. The MPTS is a statutory committee of the GMC, accountable to GMC Council and the UK Parliament. It is completely independent in its decision making and acts as an adjudication service, making decisions through tribunal hearings where fitness to practice of registrants has been called into question by the GMC.

A deductive thematic analysis of transcripts was carried out by the authors using the method described by Braun and Clarke[9–11] and adhering to the Consolidated Criteria for Reporting Qualitative Research.[12] This method was selected for flexibility, ease of access, consistency and applicability to secondary sources. The method was deductive rather than inductive, as it sought to examine specifically for character flaws identified in the surgeons in question, as viewed against Aristotelian ethical ideals. The following stages were applied to all transcripts:

- Familiarisation: The authors worked through a pilot sample of transcripts to gain an understanding of the outline of the documents and language used.
- Coding: The complete set of transcripts was reviewed and blocks of salient text assigned 'codes' which were both data driven and research driven. The authors worked separately on coding transcripts at this stage.
- Development of themes, subthemes and overarching themes: 'Codes' were used as the building blocks to establish 'themes' and 'subthemes', including establishing theme relations for example, hierarchical and/or lateral relations, visual thematic maps.

Table 1 Sanctions imposed by MPTS hearings against surgeons between 1 January 2016 and 30 June 2020

Sanction	No of cases
No action	4
Warning	4
Conditions	8
Suspension	29
Erasure	23

MPTS, Medical Practitioner Tribunal Service.

- Validating and ensuring reliability: Reliability was derived from triangulation of codes, themes and subthemes established independently and a 10% overlap of cases reviewed by each author. Validation involved returning to source data to check for consistency with the themes derived.
- Defining and naming themes: Any themes identified individually were agreed by the authors, named and defined, ensuring there was no duplication of 'central organising concepts' within separate themes (and that sub themes were 'nested' appropriately).
- Interpretation and reporting: The final agreed manuscript was developed in its current format.

RESULTS

Analysis included all hearings held by MPTS from 1 January 2016 to 30 June 2020. There were a total of 68 hearings reviewed. All surgeons involved were male and varied in their career stages, with the time since primary qualification ranging from 8 to 45 years. Sanctions handed down to surgeons by MPTS during this period are shown in table 1.

Table 2 demonstrates themes, subthemes and codes derived from the thematic analysis undertaken and agreed on by the authors, while figure 1 demonstrates a visual thematic map, demonstrating unexpected lateral relations between themes and subthemes. There were three overarching themes identified: 'the god complex', 'reputation over integrity' and 'wounded pride'.

The god complex

Within this overarching theme, there were separate subthemes of 'power plays', 'devaluing the patient' and 'no safety net'. Surgeons who faced MPTS hearings seemed to have clear trends towards abusing positions of power and exploiting trust conferred on them by patients and relatives. This often included deceiving patients and families, and on occasion more junior staff or allied health professionals, enabled by a disparity in knowledge levels. This extended in some cases to refusing to consider alternative treatment options and/or the opinions of others in the wider team, and an overly zealous belief in the value of surgery as a panacea. A recurring concept was surgeons failing to consider conservative management options, particularly when faced with the financial incentive of private practice remuneration. One case involved the MPTS tribunal 'not disposed to accept [the surgeon's] explanation for not carrying out conservative measures……[he] should have established that they had failed and/or were likely to fail before proceeding to surgery.'

In many cases, surgeons had already received 'warning shots' from their employers in advance of the MPTS hearing, but had failed to heed concerns expressed to them. This extended to denying patients the opportunity to voice concerns as a recurring theme, a lack of demonstrable insights into limitations or maverick behaviour and a feeling of being 'above the law' with

Table 2 Thematic analysis with overarching themes, themes, subthemes and code

The god complex					Reputation over integrity				Wounded pride
Power plays			Devaluing the patient	No safety net	Pursuit of glory			Covering tracks	Childishness
Personal power	Arrogance	Surgery as panacea	Failure to heed external concerns regarding technique	Denying recourse for complaint	Not knowing when to stop	All about me	Over-confidence	Evading responsibility/ accountability	Wounded pride
Power play with patients/relatives	Aloof	Not considering conservative management options	Unwilling to consider alternatives (doctor always knows best)	Failing to register with a regulatory authority	Over-diagnosing to justify surgery	Pursuing personal/ institutional glory as predominant driver	Risk taker	Dishonesty	Volatility
Superiority of knowledge as potential for abuse	Defensive		Failure to respect autonomy	No insight into limitations	Incentivised surgery	Own reputation more important that that of the profession/professional integrity	Not seeking advice/second opinion	Pursuing more invasive treatment to correct/conceal previous mistakes	Lack of restrain
Abuse of power	Deflecting blame		Objectification for sexual gratification	No pursuit of high standards/ maintenance of standards	Cutting corners		Believes own ability superior to colleagues	Self-preservation as overriding principle	Lack of insight
Abuse/exploitation of trust	Dismissive of rules, regulations and administrative processes, selfish		Failure to respect boundaries of doctor/patient relationship	Failure to cooperate with investigations	Aggressive management strategies			Deception in concealing actions	Self-centredness
Untouchable	Self-righteous		Disregard for feelings of others	Being 'above the law'	Treating scans rather than patients	Pursuing own agenda		Pursuing a false narrative	Overreaction to provocation
Undermining dignity to assert superiority	Argumentative		Opportunistic abuse of vulnerability/incapacitated state	Lack of insight into limitations	Prioritising expediency over quality	Deception above and beyond the minimum bar to 'over achieve' on paper		Minimising responsibility by citing provocation	Excessive sensitivity to judgement on performance
Deception of chaperone/staff by virtue of lack of experience/ confidence/knowledge	Vulgar		Imposing decisions/pressuring patients to take decisions	Contravening MDT advice	Unwilling to accept responsibility	Attempts to minimise perceived value of negative actions unbecoming of a doctor as 'isolated events'		Preserving a fragile veneer of integrity at any cost	Identity irrevocably tied to role and unable to reconcile threats to this
Hubris	Boastful		Not allowing due consideration of risks/benefits in the pursuit of own agenda	Falling short of standards	Minimising offending behaviour	Playing the martyr		'Whitewash'	Unwillingness to take criticism on board
Inability to perceive value in the contributions of others	Greedy		Predatory behaviour	Impervious to the idea of possible failure	Need to avoid criticism and scrutiny	Quick to cite an overwhelming workload as mitigation for 'acting out'		Backtracking to preserve the 'show' of professionalism	Quick to transfer/ apportion blame
Keeping patients in the dark	Contemptuous		Pressurised decision-making	Maverick		Pursuing own standards rather than the patient's		Painting own version of events	Vanity
Taking advantage of vulnerability			Rushed/hurried manner	Experimental treatments		Embellishing truth for personal gain		Wilfully deceptive	Citing external standards
Transgressing boundaries			No concern for feelings or discomfort	Unwilling to seek second opinion				Deliberately misleading	as unreasonable rather than accepting falling short of said standards
Playing on ignorance				No chaperone offered for intimate examinations				Intending to deceive	
Aggressive manner to assert superiority								Not backing down when confronted with facts	

MDT, Multi-Disciplinary Team.

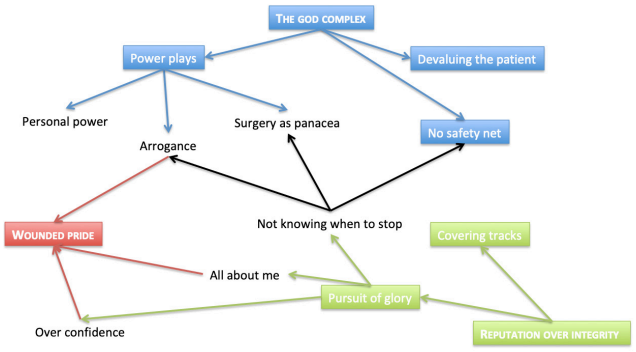

Figure 1 Visual thematic map of hierarchical relationships, including lateral relationships, between themes and subthemes.

no deference paid towards 'safety nets' such as insurance or professional regulation in many instances.

The tendency to devalue and dehumanise patients encompassed a failure to respect autonomy, pressurised decision making and on more than one occasion a failure to respect professional boundaries which at the extreme ends included objectification for sexual gratification and opportunistic abuse of vulnerable or incapacitated states. Concerns were raised by patients about overt examples of this behaviour, including one surgeon who was described as 'acting in a rushed, aggressive, insensitive and disrespectful manner', performing intimate examinations without the offer of a chaperone. Another surgeon who faced sanctions imposed by MPTS, repeatedly approached a patient with written correspondence to attempt to start a romantic relationship, stating at the outset to the patient that he was 'taking advantage of the information I have about you and I am sure you will feel that I have dipped below your expectation and belief in me as a doctor.'

Reputation over integrity

Within this overarching theme, subthemes were the 'pursuit of glory' and 'covering tracks'. Surgeons demonstrated a recurring attitude of prioritising personal achievement and glory over quality of care or professional integrity. This manifested as risk taking behaviour and a need to avoid criticism and scrutiny. As this played out, many would appear to 'play the martyr', citing overwhelming workloads and embellishing details to paint a picture that effectively shifted blame. In many cases, surgeons would attempt to conceal mistakes, which on occasion translated into redoing operations to cover up previous blunders (eg, converting a unicompartmental joint arthroplasty to a total joint replacement on realising that the first surgery had involved the wrong compartment). These additional operations were done without informing patients of mistakes, and often involved concealing the previous errors from general practitioners in written correspondence.

Some cases highlighted a behaviour pattern of deception beyond that which would satisfy minimum bar requirements, as in the case of one surgeon who falsified prior clinical experience far in excess of what would be required, 'putting himself forward with a degree of exaggeration…that he might be employed in a position he was not suited to, causing potential risks to patients.' This deception was also extended to patients, where in another instance, the surgeon concerned 'deliberately exaggerated the risk that the patient would develop cancer and advised either the necessity of undergoing continuing surveillance of their symptoms at further consultations or, on some occasions, the undertaking of various surgical procedures—none of which was necessary to maintain their health.'

Essentially, there was a trend to pursue self-preservation at all costs, even if this meant deceiving patients and colleagues to preserve a veneer of false excellence, by relentlessly pursuing false narratives up to and including the MPTS hearing. On more than one occasion, transcripts remarked that the surgeons in questions failed to demonstrate insight or any attempts at remediation, effectively resulting in harsher sanctions.

Wounded pride

This followed on from previous subthemes but was deserving of its own place as an overarching theme. The pursuit of a seemingly spotless reputation by concealing mistakes and shifting blame also manifested as an unwillingness to accept criticism. On occasion, this would appear as excessive sensitivity to judgement on performance, overreaction to provocation and volatile behaviour with staff and colleagues alike. In some cases, when confronted with standards to which they had not adhered, surgeons would go so far as to question the validity of the standards rather than their own performance. In one instance, where the surgeon in question faced criminal charges (the MPTS hearing erasing the registrant), it was stated that 'during police interviews and throughout his trial, (the surgeon) maintained his innocence and adopted a position of arrogance.' The complete unwillingness to consider the possibility of being at fault was glaring in this instance. The unwillingness to consult with colleagues also left some surgeons effectively 'operating in a vacuum', where their clinical practice became progressively deviating from the norm of treatment provided. In the case of one registrant who repeatedly provided 'experimental' treatment to patients with no evidence base, it was stated that he 'failed to treat patients' conditions conservatively, resorting to surgery too early; undertook surgical procedures and interventions which were not clinically indicated; and failed to consult with colleagues.' The same surgeon repeatedly 'failed to communicate to his patients the risks of the procedures, their experimental nature, or the likelihood of their making conditions worse not better', as well as 'repeatedly disregarding guidance about communicating adequately with patients, particular in relation to obtaining consent.'

DISCUSSION

Data available from the Health and Social Care Information Centre 2014 workforce census and Joint Committee on Surgical Training in 2015 estimate a total of 17 178 surgeons across all specialties, including 7.285 Consultants.[13] The cases discussed here, therefore, represent a very small proportion of surgeons, specifically 0.001% of surgeons per annum facing MPTS panels. It is interesting that all those involved were male surgeons. Women in surgery still represent a minority, although this appears to be increasing, with female surgeons accounting for 11% of consultants, but 30% of surgical trainees.[13] It has been noted that male doctors overall are far more likely to face disciplinary hearings and receive sanctions.[14–16] Previously postulated theories for this discrepancy have included differences in communication styles (suggesting that women communicate more effectively with patients), differences in the threshold of tolerance by the public and/or the regulatory body and differences in working patterns (fewer patient interactions as a result of higher rates of less than full time equivalent working among female doctors).[17 18]

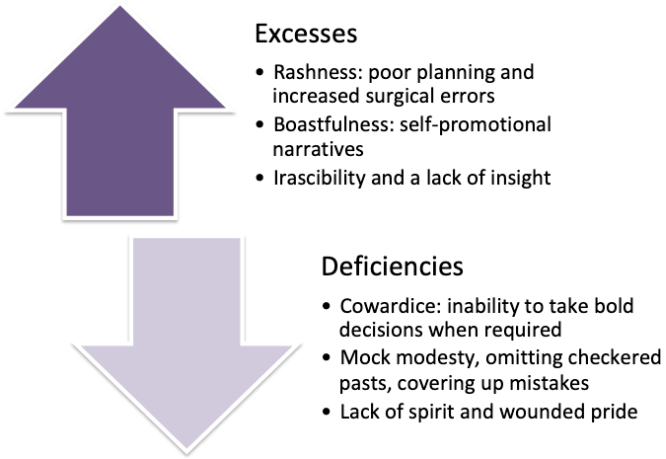

Figure 2 Excesses and deficiencies identified in the MPTS hearings based on Aristotle's model of the golden mean. MPTS, Medical Practitioner Tribunal Service.

Furthermore, it was highlighted in the GMC commissioned report Fair to Refer? that employers and healthcare providers were more likely to refer doctors who obtained their primary medical qualification outside the UK and those who were from a black and minority ethnic background.[19] It is some small comfort that a follow-up study demonstrated that the seriousness of regulatory outcomes was unrelated to these characteristics, but rather to engagement with the process (attendance and legal representation), prompting the GMC to redefine support mechanisms for doctors facing tribunal proceedings.[20]

In the Nicomachean Ethics[7], Aristotle highlighted the concept of enkrateia (loosely translated as 'self-control') and its opposite akrasia as a dichotomy that is inherent to a person having sufficient self-mastery to 'do the right thing'. The aim of the virtuous life is eudaimonia ('flourishing'), achieved by pursuing the supreme good; something worth pursuing for its own sake because it is worthy of this approach. The virtuous life (arête) is the only life that can be worthwhile in Aristotle's vision of humanity. However, the pursuit of reputation, power, money and sexual gratification are recurring themes within the cases reviewed. The pursuit of these ends highlights a number of character flaws which are problematic in any ethical framework. We are interested in using Aristotle's concept of the golden mean to engage in ethical analysis because it focuses less on the wrong actions which are laid out clearly in the tribunal records, and more on the character of the person making problematic choices and performing harmful actions which flow from their character.

Aristotle laid out the doctrine of the mean, where habituation leads one to pursue virtue and avoid excess or deficiency. There are a number of virtues which are relevant to a better understanding of this group of surgeons, including courage, truthfulness and good temper, highlighted in figure 2. The aim for a surgeon is to find an equilibrium, which is person and context specific. A 'good' surgeon is not just a technically proficient one, they are also a surgeon whose character aims for the mean between excess and deficiency in the moral choices inherent in a career in surgery. The tribunal records provide a view of the surgeon at the time of the events which led to the referral for fitness to practice and a contemporary record of their current character, as seen through character witnesses, employer statements, patient testimony and the personal statements the surgeon makes during the tribunal hearing. Thus, our coding of character flaws was based on a longitudinal analysis rather than judgements about isolated incidents.

Using the golden mean, we can see that a surgeon often needs courage during the planning and conduct of an operation. Too little courage leads to cowardice, where the full ambition of an operation may not be achieved, while too much courage leads to rashness, where an operation is conducted without proper planning or in a way which increases the likelihood of surgical errors. In both the deficiency and excess, patient harm is more likely. A common theme for many cases was the overzealousness in surgery and regard of the scalpel as a panacea despite evidence to the contrary. Phronesis informs good judgement and it is commonly said that while the good surgeon knows when to operate, the excellent one knows when to stop. Take for instance comments about one surgeon who 'repeatedly disregarded guidance about communicating adequately with patients' and 'failed to communicate to his patients the risks of procedures, their experimental nature, or the likelihood of making conditions worse not better'. Overreaching and greed (pleonexia) are vices highlighted by Aristotle's Ethics that are echoed here in the safeguarding of one's own reputation above that of the profession, impairing judgement.[7]

If truthfulness is the mean, then most surgeons in the data set had components of boastfulness which manifested in various ways throughout the tribunal record. The relentless pursuit of personal glory may lead surgeons who have fallen from grace to cut corners in the interests of expediency, cover their tracks and almost overcompensate. In some cases this may extend to falsifying case notes and job applications, in particular omitting chequered pasts, but in the worst instances this behaviour can lead to repeated surgeries on uninformed patients to cover up mistakes. Magnanimity (megalopsuchia) stands in stark contrast to vanity and wounded pride in the Ethics and finds representation in the MPTS cases in additional behaviours such as playing the martyr and shifting the blame to institutional failings, surgeons citing themselves as the exception and pursuing a self-promotional narrative until the very end in an attempt to preserve an ever more fragile veneer of a pristine personal reputation, to the detriment of that of the profession.[7]

Many surgeons also presented with an excess of irascibility (the tendency to be easily angered). Maintaining the mean of a good temper is challenging in stressful situations such as complex patient interactions and surgical procedures, but if the surgeons character is irascible, they are more likely to behave unprofessionally. Some surgeons demonstrated their irascible nature during the tribunal hearing, both verbally and in writing. Some surgeons declined to attend the tribunal hearing for a variety of reasons but chose to engage in argumentative written communication with the GMC prior to the Tribunal.

In certain cases, it was not possible to discern a precise set of character traits which fitted into a golden mean framework. Some surgeons had complex patterns of behaviours and attitudes which were extreme even for this data set. Abuse of trust in the pursuit of power can be seen in cases such as that of one surgeon whose behaviour was described as 'aggravated by the power imbalance between himself and those he subjected to his behaviour.' In other cases, this took various forms including keeping patients and/or colleagues in the dark by abusing a disparity in knowledge and understanding, preying on vulnerabilities and transgressing the professional boundaries of the doctor–patient relationship.[21] Surgeons in many of the cases had a tendency to 'dehumanise' the patient and denying recourse to a safety net of all the protection that would ordinarily be extended to a patient who is cared for and valued in their own

right. This dehumanisation by the worst elements of the medical profession has previously been highlighted by Foucault in his work The Birth of the Clinic, and can be seen at play in these cases.[22] Rousseau stated 'a tile that falls off a roof may injure us more seriously, but it will not wound us so deeply as a stone thrown deliberately by a malevolent hand.[23]' The issue of intent or volition is seen in many of the MPTS hearing transcripts, such as descriptions of the actions of one individual as 'intentionally harmful', 'a pattern of lies, deceit and exploitation of patients', representing 'the antithesis of the Hippocratic Oath'. The distinction between voluntary (hekousion) and involuntary (akousion) acts is clearly made by Aristotle in the Nicomachean Ethics as a marker of the representation of an unchanged disposition or character.[7] Indeed, this pattern of behaviour is seen as the focus of deliberation in the Tribunal at sanction stage, where surgeons who failed to demonstrate insight or remediation over prolonged periods were more likely to receive increasingly severe sanctions, resulting in erasure where deemed necessary.

Phronesis in surgical training

One may wonder what the value is in citing character failings or examining surgeons fallen from grace through the lens of Aristotelian virtue ethics. A key consideration is that these dispositions or character traits may be amenable to change. Character flaws may manifest themselves early in training in behaviours such as overselling oneself or overstating experience (boastfulness), 'gallows humour' or 'black humour' (tastelessness), an unwillingness to accept criticism (vanity), a reluctance to ask for help (pride), regarding surgery as a panacea (greed and rashness) and failing to consider other options or concede to patient autonomy and choice.

Morally informed action requires self-exploration against standards of professionalism in terms of virtues, values, beliefs, attitudes, feelings and ideals. The practice of surgery embodies the development of wisdom through experiential learning (*praxis*) in the context of a community that fosters professional judgement, to be able to act within a tradition but also to critique it.[24] By 'reverse engineering', we may be able to identify these traits in trainees at the point of recruitment or early in training and habituate positive attributes (phronesis) rather than merely handing trainees a rule book and measuring tape. The hope is that one can be eudaimon through habituation, a learnt process, making the case for this in postgraduate surgical education and training.

The concept of the golden mean per se is not sufficient of its own accord to underpin postgraduate surgical training. It is context specific for both the clinician and the patient at any given moment in time and the focus should be on enabling trainees to adjudicate conflicting values for a given situation, providing 'an essential connection between seeing or understanding what is right or good and knowing how to do good.[25]' Bontemps-Hommen *et al*[26] have proposed a new heuristic definition of phronesis in light of the complexities of modern medical practice that highlighting ever-changing practices and contexts whereby 'the good appears to be fluid, is rarely quantifiable, and it cannot easily be generalised'. The concept of practical wisdom (phronesis) is needed in postgraduate surgical training as a character reformation rather than just imparting practical skills within the limited ethical frameworks of duty and consequentalist-based ethical systems.[27]

Twitter Ross Elledge @ElledgeSurgical

Contributors On behalf of myself and my coauthor, I can confirm that both authors have made a valid contribution to the work. Both were involved in the inception and original idea of the project, sourcing relevant material from MPTS, independent thematic analysis, discussion of the results and preparation/critical revision of the resultant manuscript. Both authors have approved the final version of the manuscript for submission and the most recent revision. Neither author has any conflicts of interest to declare.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Ethics approval No patients were involved in this research. Disclosure of all records was approved by the Medical Practitioners Tribunal Service (MPTS), but all records have previously been accessible in the public domain for a finite time period. Formal ethical approval was not required and has not been sought.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data may be obtained from a third party and are not publicly available.

1 Beard J, Bussey M. Workplace-Based assessment. *Bulletin* 2007;89(5):158–60.
2 Chou E, Abboudi H, Shamim Khan M, *et al*. Should surgical outcomes be published? *J R Soc Med* 2015;108(4):127–35.
3 Kingsley C, Patel S. Patient-Reported outcome measures and patient-reported experience measures. *BJA Education* 2017;17(4):137–44.
4 General Medical Council. *Good Medical Practice*. © GMC, 2013. Available: https://www.gmc-uk.org/-/media/documents/good-medical-practice-english-20200128_pdf-51527435.pdf?la=en&hash=DA1263358CCA88F298785FE2BD7610EB4EE9A530
5 Elledge R, Brennan PA, Mohamud A, *et al*. Phronesis and virtue ethics: the future of surgical training? *Br J Oral Maxillofac Surg* 2020;58(2):125–8.
6 Hursthouse R. *On virtue ethics*. ©. Oxford University Press, 1999.
7 Aristotle RWD, Brown L. *The Nicomachean Ethics*. Oxford University Press: Oxford, 2009.
8 Grundy S. *The Curriculum: Product or Praxis*. London: Falmer Press, 1987.
9 Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006;3(2):77–101.
10 Braun V, Clarke V. Thematic analysis. In: Cooper H, ed. *APA Handbook of Research Methods in Psychology*. Washington DC: APA books, 2012: 2. 57–71.
11 Braun V, Clarke V. Thematic analysis. In: Michalos AC, ed. *Encyclopaedia of quality of life and well-being research*. New York: Springer, 2014.
12 Nowell LS, Norris JM, White DE, *et al*. Thematic analysis: striving to meet the trustworthiness criteria. *Int J Qual Methods* 2017;16:1–13.
13 Surgery and the NHS in numbers. Available: https://www.rcseng.ac.uk/news-and-events/media-centre/media-background-briefings-and-statistics/surgery-and-the-nhs-in-numbers/ [Accessed 24 Oct 2020].
14 Alam A, Klemensberg J, Griesman J, *et al*. The characteristics of physicians disciplined by professional colleges in Canada. *Open Med* 2011;5(4):e166–72.
15 Unwin E, Woolf K, Wadlow C, *et al*. Disciplined doctors: Does the sex of a doctor matter? A cross-sectional study examining the association between a doctor's sex and receiving sanctions against their medical registration. *BMJ Open* 2014;4(8):e005405.
16 Kohatsu ND, Gould D, Ross LK, *et al*. Characteristics associated with physician discipline: a case-control study. *Arch Intern Med* 2004;164:653–8.
17 Bloor K, Freemantle N, Maynard A. Gender and variation in activity rates of hospital consultants. *J R Soc Med* 2008;101(1):27–33.
18 Taragin MI, Wilczek AP, Karns ME, *et al*. Physician demographics and the risk of medical malpractice. *Am J Med* 1992;93(5):537–42.
19 General Medical Council. Fair to refer? © GMC, 2019. Available: https://www.gmc-uk.org/-/media/documents/fair-to-refer-report_pdf-79011677.pdf
20 Caballero JA, Brown SP. Engagement, not personal characteristics, was associated with the seriousness of regulatory adjudication decisions about physicians: a cross-sectional study. *BMC Med* 2019;17(1):211.
21 Dyer C. Surgeon who made repeated sexual comments about staff is suspended for nine months. *BMJ* 2019;364.
22 Foucault M. *The birth of the clinic: an archaeology of medical perception*. London ©: Tavistock, 1973.
23 Rousseau JJ, Butterworh CE. *The Reveries of the solitary Walker*. New York: © New York University Press, 1973.
24 de Cossart L, Fish D, eds. *Cultivating a thinking surgeon: new perspectives on clinical teaching, learning and assessment*. Shrewsbury: TFM Publishing Ltd, 2005.
25 Pellegrino ED, Thomasma DC. *The virtues in medical practice*. Oxford: © OUP, 1993.
26 Bontemps-Hommen CMML, Baart A, Vosman FTH. Practical wisdom in complex medical practices: a critical proposal. *Med Health Care Philos* 2019;22(1):95–105.
27 Burnyeat MF. Aristotle on learning to be good. In: Rorty AO, ed. *Essays on Aristotle's Ethics © University of California Press*, 1980.